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BREAKING: Patients potentially exposed to infection at Winnebago IHS hospital

CDC conducting review on incident at local hospital

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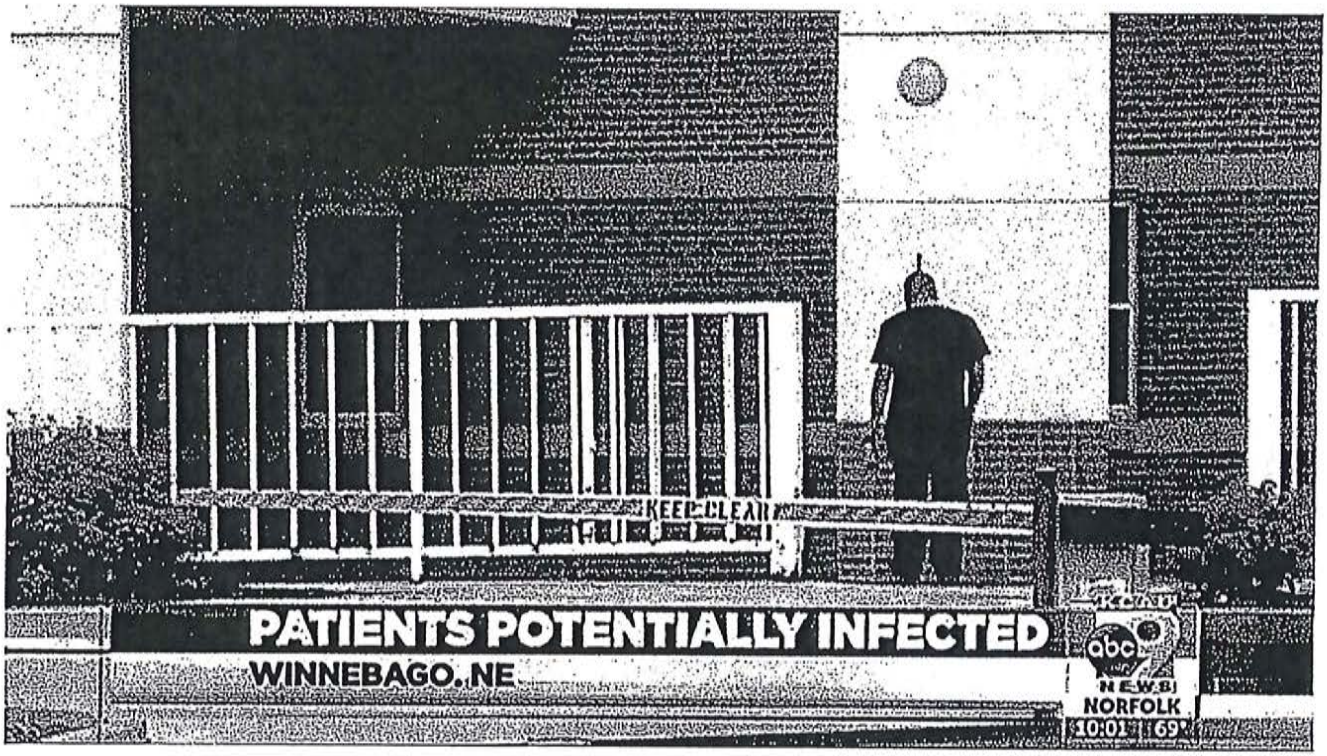

Winnebago, Neb. - Patients who received care at IHS hospital in Winnebago may have been exposed to several diseases after tribal officials confirm that a medical instrument may not have been properly sterilized.

According to a statement from Tribal Chairman Frank White, patients who received care at the Podiatry Clinic at the Omaha-Winnebago IHS Service Unit in Winnebago between April 17th and June 2nd of 2017 may have been exposed to infection.

EXHIBIT 5 tabbies

Officials say that a consultant from AB Staffing Solutions was terminated once the possible cross contamination was discovered. The Podiatry Clinic has also been temporary closed as the tribe looks into implementing procedures to ensure future incidents don't occur. IHS staff is in the process of contacting patients who may have been exposed and recommends that exposed patients be tested for hepatitis B, hepatitis, C and HIV. So far 35 patients have been recommended for testing, 23 of which live in the Winnebago community.

In the letter obtained by KCAU9, Tribal Officials say they are quote "Extremely concerned and distressed due to the lack of communication and urgency in this matter by IHS officials. Even more so, the obvious negligence and lack of safety protocol on behalf of the IHS provider in this case. This incident compounds the existing distrust with IHS and the ongoing and apparent lack of attention to correct the serious deficiencies including procuring qualified, professional staff."

The Center for Disease Control and Prevention is currently conducting an in-depth review of the incident.

Patients with questions or concerns about the recent exposure are being asked to call the Winnebago Tribal Health Department at 402-878-2294.

The IHS hospital in Winnebago has faced a number of issues in recent years. In July of 2015 the hospital lost its Medicaid funding after reports of poor patient care, which led to a patient's death. Later, in August of 2015, IHS sacked four top officials after a joint resolution by the Winnebago and Omaha Tribes calling for healthcare reform.

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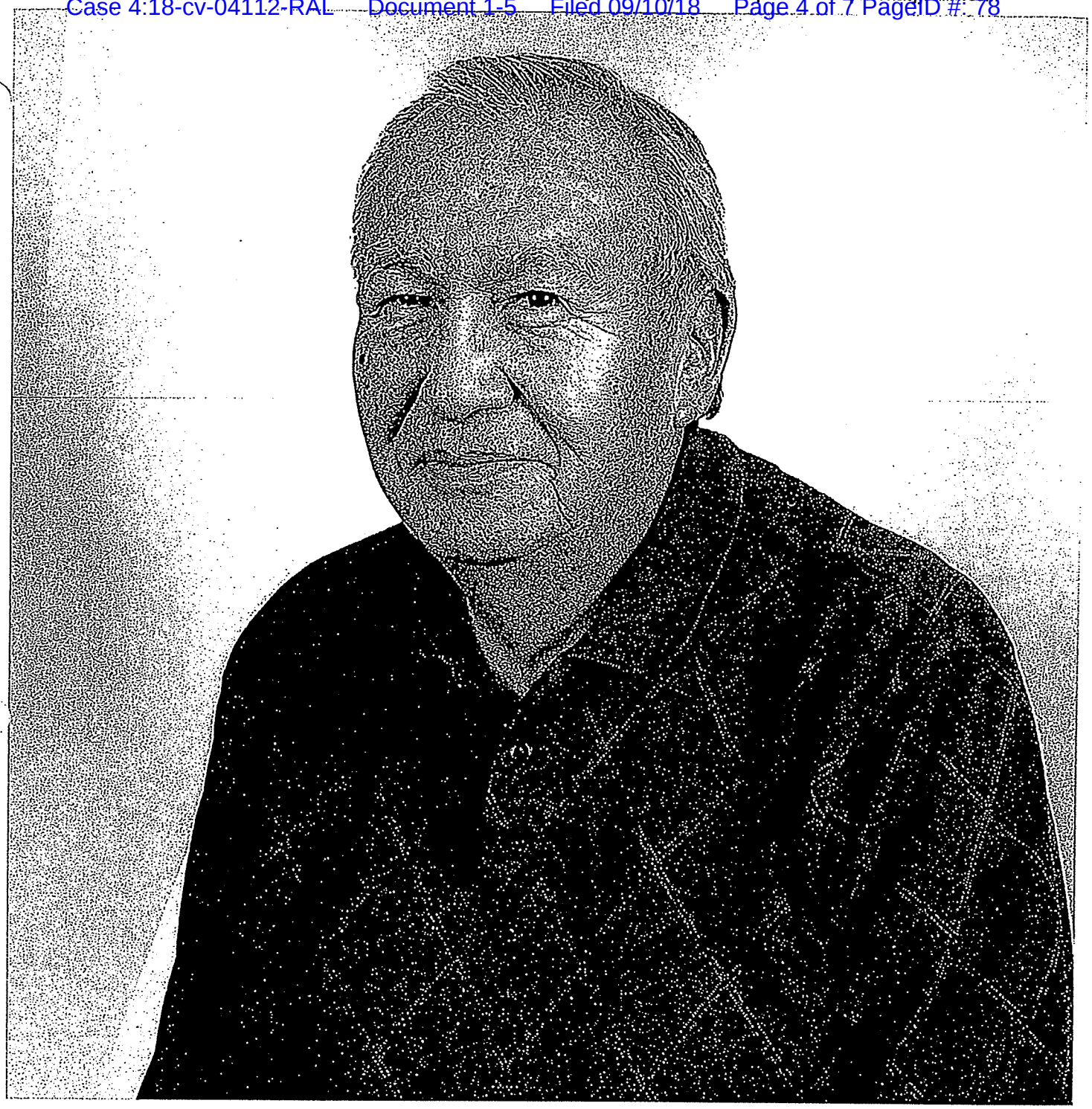
http://siouxcityjournal.com/news/local/winnebago-clinical-director-tribal-confidence-shaken-by-latest-hospital-miscue/article_c01282c6-6f0f-5469-b35e-520cf7934327.html

BREAKING TOP STORY

Winnebago clinical director: Tribal confidence shaken by latest hospital miscue

MASON DOCKTER mdockter@siouxcityjournal.com Aug 3, 2017



White

WINNEBAGO, Neb. | The clinical director of the Winnebago Indian Health Service hospital conceded Thursday that public confidence in the tribal hospital has been further shaken following reports that up to 35 podiatry clinic patients may have been inadvertently infected with diseases that include HIV and Hepatitis.

Between April 17 and June 2, a podiatry instrument was not properly sterilized between procedures, raising concerns of blood-borne diseases potentially being transferred from patient to patient, according to the hospital. The podiatrist responsible for the error has since been terminated, and the clinic remains temporarily closed.

"I don't know if they're going to trust us. I don't know when we get the trust back," said Dr. Virgilio Cantu, clinical director of the Winnebago hospital, which serves members of the Winnebago and Omaha tribes of Nebraska.

Winnebago Tribal Council Chairman Frank White said the embattled hospital didn't have a vote of confidence from the community to begin with.

"The trust -- it wasn't there before, and this just makes it worse," White said.

White rattled off a myriad of shortcomings at the hospital, operated by the Aberdeen, South Dakota-based Great Plains Area Indian Health Service, dating to well before the latest disclosure.

"In recent years, we've had deaths at the service unit due to incompetent staff," he said.

Root of the problem

The Center for Disease Control and Prevention (CDC) is investigating the latest incident, which Cantu blamed on Dr. John Horblein. Horblein started working in Winnebago in April after the hospital contracted with Arizona-based AB Staffing Services for podiatry services after the hospital's previous podiatrist left.

"During the course of his treating patients, it came to our attention that sterilization of the scalpel handle would not occur between patients," Cantu told reporters Thursday. "That can cause an infection."

The blade of the instrument, Cantu noted, was sterilized between procedures, which reduced the chance of infection.

"The risk, although it's minor, it's very small, it's still a risk," he said.

The hospital's investigation found 35 patients had undergone invasive procedures during that time period. None are currently known to have contracted a disease as a result of the contamination.

The hospital contacted the CDC and the Nebraska Department of Health and Human Services, which advised that all patients be tested for Hepatitis and HIV.

"I'm going to say it this way: we reviewed the records of all the patients that were seen in the clinic, and of those 35, no one had any signs or medical history that indicated they had Hepatitis B, Hepatitis C or HIV," Cantu said.

A nurse noticed the physician had improperly sterilized the instrument. The clinic closed June 3, a day after hospital officials were notified of the problem, Cantu said.

Horblein was immediately dismissed from the hospital. Cantu said Horblein is under evaluation, but he is uncertain whether he remains licensed or is still practicing.

Delayed disclosure

As of this week, he said, the hospital began testing patients for possible infection. If any of the patients are found to be infected with HIV or Hepatitis, Cantu said the hospital is ready to help. Hospital officials are considering working with a group of specialists at the University of Nebraska Medical Center.

Cantu attributed bureaucratic processes for the more than two-month delay in disclosure the matter to the public.

"It was very quick, I've never seen it operate this fast," Cantu said. "But still it caused a bit of a delay. And I guess that's what everyone verbalizes -- 'Why did it take so long?' We want to make sure we had the correct information."

Cantu said it would not have been prudent to administer HIV or Hepatitis tests earlier because the tests can't detect antibodies before a certain amount of time has passed.

"If we were to say, 'We think you've been exposed, come in for testing,' on the fifth or on the sixth, two days, three days later, our immune system hasn't had a chance yet to develop a response," Cantu said. "Any testing we would have done, would have been negative. And the patients would have been sent home thinking, 'My tests are okay.'"

White, the Winnebago tribal chairman, clearly was not happy that it took so long to disclose the incident.

"I believe that they should have shared this with the tribal leaders, at least make us aware of it," he said.

As Cantu got ready to leave the Blackhawk Community Center, he and White exchanged parting words. There was an audible stiffness.

"We'll be in contact," Cantu said to White.

"Yes, we will," White replied.

MORE INFORMATION

Winnebago clinic patients may have been exposed to HIV, hepatitis

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